STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING _____ B. WING _____	R-C 10/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF ROAD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was the Post Survey Revisit (PSR) to the Investigation of Complaint IN00095419 completed on September 6, 2011. This visit was done in conjunction with the Investigation of Complaint IN00096308. Complaint IN 00095419 Corrected. Survey dates: October 5 and 6, 2011 Facility number: 012448 Provider number: 155785 AIM number: N/A Survey team: Anne Marie Crays RN Census bed type: SNF: 26 Residential: 52 Total: 78 Census payor type: Medicare: 19 Other: 69 Total: 78 Sample: 5 West River Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00095419. Quality review completed 10/12/11 Cathy Emswiller RN	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE